

JUN 8 1918.

UNIV. OF MICH.

# THE RHODE ISLAND MEDICAL JOURNAL



Owned and Published by the Rhode Island Medical Society. Issued Monthly

VOLUME II } Whole No. 120  
NUMBER 6 }

PROVIDENCE, R. I., JUNE, 1918

PER YEAR \$2.00  
SINGLE COPY 25 CENTS

## CONTENTS

### ORIGINAL ARTICLES

Some Cardio-Vascular Considerations in Connection with Advisory Draft Board Examinations.	
George S. Mathews, M.D.	85
Epidemic Meningitis. Carl D. Sawyer, M.D.	88
A Case of Simultaneous Fracture of Six Long Bones.	
Roland Hammond, M.D.	91
Report of the First Case of Pellagra in 1918.	
Henry A. Jones, M.D.	92

### EDITORIALS

Scientific Medicine and the War	94
The Life Extension Institute	95
The Irregular Cults in the War	96
More Medical Officers	97
A Medical Survey	97

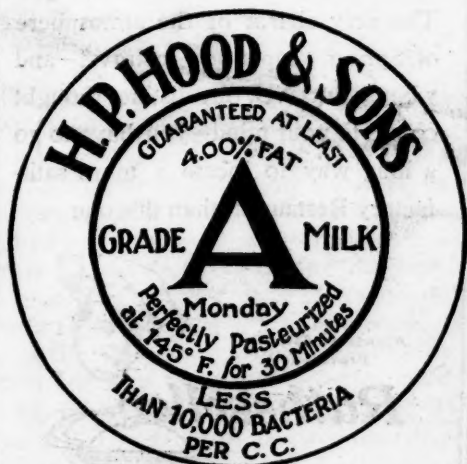
### SOCIETIES

Providence Medical Association	97
Washington County Medical Society	98
Woonsocket District Society	98
Kent County Medical Society	98

### MISCELLANEOUS

The Supreme Court Decision on the Corporate Rights of the American Medical Association	93
Mobilization of the Rhode Island Hospital Unit	98
Honor Roll	99
Letter to the Editor	99
Book Reviews	100

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE AT PROVIDENCE, R. I., UNDER ACT OF MARCH 3, 1879



We take pleasure in announcing that  
**Bonnie Brook Farm Milk**

Can now be purchased in Providence

Bonnie Brook Farm is our latest acquisition to the chain of special milk farms. It is in South Sudbury, Massachusetts. The farm is conducted under the highest standards of dairy management and sufficient proof is offered by the fact that it is

**CERTIFIED**

by

**The Boston Medical Milk Commission**

Physicians are invited to prescribe Bonnie Brook Farm Milk for their patients. We are confident that it will fully measure up to their desire for a **FRESH, CLEAN, SAFE MILK.**

**H. P. HOOD & SONS**

**Dairy Experts**

**Send Your R Work to the Largest Optical House in Rhode Island**

## HOPE OPTICAL CO.

*Wholesalers and Jobbers*

63 WASHINGTON ST.

PROVIDENCE · R.I.



We Offer You as Specialties

## KRYPTOKS—CROOKS

We are

The only Optical House in Rhode Island Licensed to Grind

## ULTEX ONE-PIECE BIFOCAL

The Bifocal de Luxe

## Narragansett Hotel

Leading Hotel in Providence

Headquarters for all  
Professional and Business Men

Cool Spacious Dining Room

Reasonable a la Carte Prices

## The Time of Year to Travel

The very charm of the atmosphere of Spring tempts you to travel—and when you travel, one distinct thought comes to your mind—you have to go a long way to locate a more satisfactory Restaurant than this one

Alongside City Hall  
Providence

**Rathskeller**



# THE RHODE ISLAND MEDICAL JOURNAL

The Official Organ of the Rhode Island Medical Society  
Issued Monthly under the direction of the Publication Committee

VOLUME II }  
NUMBER 6 } Whole No. 120

PROVIDENCE, R. I., JUNE, 1918

PER YEAR \$2.00  
SINGLE COPY, 25 CENTS

## ORIGINAL ARTICLES

### SOME CARDIO-VASCULAR CONSIDERATIONS IN CONNECTION WITH ADVISORY DRAFT BOARD EXAMINATIONS.\*

By GEORGE S. MATHEWS, M. D.

The medical man examining registrants for military service is eager to recommend for acceptance all who are fit and is equally anxious to exclude those who are unfit. A large majority of cases can be classified readily as worthy or as unworthy of acceptance. Not a few, however, tax the mental acumen of the examiner. No one is more severely distraught than the one whose duty it is to pass judgment on the heart and lungs. It is true that instructions more or less elaborate and minute have been issued in the form of a "Manual of Instructions" for Draft Boards and for Medical Advisory Boards, prepared under the direction of the Surgeon General of the army. These instructions are, of course, scientifically up to date, and are a compend of the recent knowledge of the subject. Nowhere in so small a compass can as much information be obtained on the subjects under discussion. But with all the specificity as to detail there is a great opportunity for the examiner to get stranded on the rocks of doubt or to eddy in the currents of uncertainty. Fairness to the registrant, justice to the Government rings many a qualm of conscience from the experienced. After all, the best judgment of the examiner is given and is based on a careful survey of the facts presented and their interpretation. The recognition of signs and symptoms, their correlation and their proper interpretation, all combined, go to make up an opinion worth while. The failure to recognize the facts, the failure to correlate them, will, of course, result in a wrong interpretation. It is true that much of the work

is done with rapidity, and in order that there be no lost motion a well thought out system or routine will greatly expedite the elimination of waste and the economy of action. A wide-awake chairman or secretary can arrange the cases for the respective examiners in a way that will make much for celerity. In the board with which the writer is associated the chairman, Dr. George L. Collins, has arranged the examinations in such a way as to cause the least overlapping and reduplication of labor. In regard to the registrants who are drawn from all vocations and walks of life—from grimy labor to the university teacher—almost without exception were they bodily clean and neatly clad. The exception, too, was the slacker or the shirker.

The Advisory Board of the northern section of Rhode Island has the great advantage of having commodious quarters in the Out Patient Department building of the Rhode Island Hospital. Here are ample rooms and the quiet so essential for chest examinations. The cramped quarters with the noise, confusion and distractions incident to the simultaneous examination of a number of applicants by different examiners must hamper the careful auscultation of the chest. Even under ideal conditions of quiet the tension of nerves is great in the rapid though systematic and careful examination of chest where eyes, ears, fingers and brain are in active requisition. Even under the most favorable circumstances Homer may nod.

In the course of a routine examination of the chest a definite plan and orderly scheme was followed. Inspection, palpation, percussion and auscultation in the order named were attempted. In the necessary hurry no doubt much of interest passed unnoticed. Many errors of judgment will be corrected in later work in the camps. However, much of interest was recognized.

In a few of the cases where there was a long chest the apex was located in the sixth space. In two of the cases the apex appeared in the fifth space when the recumbent position was assumed. An X ray report confirmed the diag-

\*Read before the Providence Medical Association, May 6, 1918

nosis of a ptotic heart. In none of the cases was there evidence of left ventricular hypertrophy. Apropos of the long and rather flat chest the timely article in a recent medical journal by Sir William Osler on "War Wastages" is pertinent. In his triad of "war wastages" the thin, flat chested man is a prominent offender. This man bears the rigorous life of the soldier badly.

In some of the registrants it was impossible to see or feel the apex beat even with the assumption of the left lateral position. In most of the cases this will swing out the ventricle up against the chest wall so that the apex beat can be plainly seen and felt.

An inspection of the neck, supra sternal notch, and chest for undue pulsations and palpation for thrills yielded, frequently, fruitful results. The impression was received, though it was not statistically proven, that the apex was very many times nearer the vertical nipple line than one is taught to expect. The area of cardiac dullness, too, in many cases was rather increased on the left of the sternum—and this in cases where there was no accentuation of either of the basal second sounds or a widened area of dullness to the right of the sternum. Perhaps in a few of these scientific instrumentation would have shown a right ventricular hypertrophy too slight for clinical observation, but in the form of a downward R wave.

According to the "Manual of Instructions," all cases of cardiac murmur shall be referred by the Draft Board to the Advisory Board. This class of case constituted the largest percentage of reference cases where the heart was in question. The instructions are explicit and mandatory to reject all cases with a diastolic or a presystolic murmur. On the other hand, with equal emphasis one is informed "it cannot be too strongly insisted on that, given a heart of normal size and responding normally to effort, any murmur that is heard should be considered accidental and insignificant, unless it can be positively demonstrated that it is a mitral or aortic diastolic murmur. It should also be constantly borne in mind that the excitement of the examination may produce violent and rapid heart action, often associated with a transient systolic murmur, which effects may erroneously be attributed to the effects of exertion." It is in this class of case that at times great care must be exercised. While in most cases where there is evident right ven-

tricle hypertrophy with  $P_2+$  and subjective evidence of failure of cardiac response, it is easy to decide to reject, or where the exercise test is good one may recommend a classified service. There are, however, very many cases where murmurs, systolic in time, exist—and these cases far outnumber the truly organic or valve cases—where in most of them military service is intended. In many borderland cases where after several examinations doubt exists, it would seem advisable to pass them up for observation in the real training of camp, during which training they can be followed with care, and if they fail of the mark they can be excluded. In many of the registrants a systolic murmur over the left precordium disappeared upon the exercise test. In such no doubt the tonicity of the heart was improved by the exercise and the ordinarily flabby musculature needed but the stimulation of exercise to bring the ventricles to a more positive contraction. Lack of tonicity is a frequent cause of precordial systolic murmurs. On the other hand, some of the men presented a murmur on the first excitement of the examination—a murmur that soon disappeared. Not infrequently one finds a systolic murmur at the apex after exercise with radiation to the axilla, but with a normal response to the exercise test, i. e. with no abnormal increase in pulse rate, with normal location of apex, and proper  $A_2$  and  $P_2$ .

Cardio-respiratory murmurs were very common in the cases that came under the writer's observation—murmurs that increased in intensity with full inspiration and diminished with expiration, sort of crescendo diminuendo murmurs.

The systolic murmur at the right base is one to which it is necessary to give some heed. There were only a few cases where this was the sole location of the murmur. In one there was a scarcely audible second aortic sound. In another a similarly faint aortic second was heard with a questionable diastolic whiff on deflation of the lungs. A Wasserman in the last case was negative. The rough aortic systolic sound so common in the arterio-sclerotic aorta is not to be expected in the young men examined unless, perchance, a precocious arteriosclerosis exists. Dr. Lewis pays little heed to the aortic systolic sound unless the  $A_2$  is gone.

There is another heart condition aside from murmurs where considerable difficulty may arise in deciding the admissibility of a registrant to military service. Reference is now to the



arrhythmias. Of these probably ninety per cent. fall under three headings: The sinus arrhythmia or respiratory type; the extra systoles or ectopic type; and auricular fibrillation. The type more frequently presenting itself to the draft examiner is the respiratory type. This is easily recognized as a rule by the "wave-like alternations of rapid and slow heart action." It is rapid in inspiration and slows down with expiration. It depends on the action of the vagus and is a more or less physiological phenomenon. It is this irregularity that has relegated many young men in their teens to shun exercise at the advice of their physicians and it has unfortunately made early neurasthenic invalids of many healthy young people.

Extra systole or ectopic beat is a very common type of arrhythmia. Generally easy to recognize by ordinary clinical means, it is largely of laboratory interest whether the beat originates in the auricle, in the ventricle or in the junctional portion. Generally, too, it is not of pathological importance. This statement can safely be made that what is an apparently normal heart in regard to location of its apex, valve sounds and response to the exercise test need not disturb the examiner if extra systoles occur. In nervous strain, under excitement, and even under quite normal conditions this condition may exist in some persons. It is also, on the other hand, found in various pathological conditions, as in myocarditis, hypertension, in the recovery from infectious diseases. Extra systoles were found in not a few of the hearts examined. Far be it from the statement that every case of extra systole can be readily differentiated by ordinary clinical means. In a rapid acting heart and when the extra systole comes in frequently and at irregular intervals, it may be difficult to determine whether fibrillation is not present.

Auricular fibrillation was seen in several cases. In one case during the examination fibrillation developed and continued. Pulsus irregularis perpetuus was the name at one time applied to this abnormality, but this designation does not conform entirely to the actual facts in all cases. For in some the irregularity disappears and again returns. Auricular fibrillation disqualifies a registrant. The diagnosis as a rule is easy.

What was apparently a paroxysmal tachycardia occurred in one man while under examination. During auscultation he complained of some precordial discomfort, palpitation, dizziness, and the heart beat instantly increased from about 90

to 180. The action was perfectly regular. This rapid rate continued for some three or four minutes and then resumed its first and slower rate instantaneously. Of interest in this case would have been a polygram or an electrocardiogram, for it is not impossible that the auricles might have been beating several times more rapidly than the apex or pulse beats. This may have been a case of auricular flutter.

It is a matter of more than academic interest to take the pulses of all registrants in the three stages: rest; after exercise; and after two minutes at rest after the exercise test, and to record them. To draw conclusions or to make serious deductions from the cases sent up to the Advisory Board would be unfair, inasmuch as these cases were sent up for further heart consideration. My impression is that a very large number, a majority, of these cases had a pulse rate of 80 or over. Just what a tabulation of the pulse rate of men in the draft net would show would be of some interest. The pulse varies much in any one individual. Time of day, the individual condition, excitement, nervousness, all make a difference. Cavorting with John Barleycorn in some of my men may have been a contributing factor. It is stated that some of the slackers have resorted to atropine or belladonna.

The work in England in connection with the heart in reclamation camps is of immense importance. Such eminent cardiologists as Thomas Lewis, Sir James Mackenzie, Sir Clifford Albutt are members of a commission looking to the cardiac betterment of the soldiers. Many fine articles have been appearing in the English journals in regard to the studies of this commission and the methods approved. In 1871 Dr. DaCosta published an article, epoch making, in the *American Journal of Medical Sciences* on the "Irritable Heart of the Soldier." It is a classic. For keen observation and judicial interpretation it is well worth reading. No doubt it is somewhat of a far cry from the registrant to the invalided-home soldier, but many of these cases might be anticipated. The exercise test that the man goes through with is one of the most significant requirements. One can extract from it much of great value in the placing of the man and in the elimination of the unfit. If after 100 hops on one foot there is precordial pain, palpitation, breathlessness, dizziness, exhaustion, much heed is to be taken. Dr. Lewis in a recent article concerning his work at the

Military Heart Hospital, Colchester, England, says that "it is essential that objective evidence of symptoms should in each case be found before a complaint is allowed to weigh. Most patients emphasize a single symptom and emphasize it constantly; a changing symptomatology can rarely be corroborated by outward signs, and is to be distrusted. . . . The tolerance of exercise is to be judged by physical signs and not by symptoms; symptoms are chiefly of value in directing the attention to physical signs." Breathlessness with the attendant facial expression of distress is a marked symptom of cardiac weakness after exercise. Pain over the precordial region is often found, and it will be well to examine the registrant's chest in cases of these complaints to elicit evidence of hypersensitiveness over the heart, over the pectoral folds. None of the physical signs or symptoms or all need necessarily exclude a registrant from full military service or, at any rate, from a classified service. Some will be eliminated forthwith. Many cases can be passed up to camp life and training where the proved out unfit can be eliminated after a careful tryout.

In the invalided home soldiers in England many marked cases of irritable heart have been returned to active military work after due patient training in graduated camp work. Many are reclaimed for special service. All of them otherwise would have landed high and dry as physical derelicts. Careful scrutiny in the early examination of recruits is needed, watching for the symptoms already mentioned: breathlessness, exhaustion, precordial pain, et al. Not all exhaustion may be due primarily to the heart. In many of the limp, lackadaisical it may be due to acidosis—to retained  $\text{CO}_2$  or to retained  $\text{CO}_2$  and what physiological chemists call bunker salts. Also faintness may be due to vaso motor depression as, for example, when on standing in a warm room there may be anemia of the brain due to vaso dilation of the vessels of the lower extremities or of those of the abdominal organs.

The systolic blood pressure in many of the men was rather high. Before exercise and in a recumbent position in a rather large number a systolic pressure of 160 or higher was obtained with a varying and as a rule not abnormal diastolic reading, and in cases where there was no evidence of left ventricular hypertrophy or a sharp  $A_2$ . In some of these under similar condi-

tions a week or two later there was a more normal reading. In some, however, the high pressure persisted and without discovered cause. Where a high pressure was found the urine was examined. It would be a matter of practical importance where cardiac weakness is suggested to take the pressure first in the recumbent position; next, after the exercise test when one should get an increase in the blood pressure; and finally some minutes after the exercise test when the blood pressure should return to that of the first reading. Of course all this is time consuming, but telling information no doubt could be obtained.

The statistics that are accumulating in regard to registrant examinations will be illuminating. In an analysis of some 9,000 cases one writer noted that 29 per cent. were rejected on physical grounds. Eyes, teeth, weight, in the order named, were the largest contributing causes. The heart was responsible for about  $2\frac{1}{2}$  per cent. of rejections. It is stated by competent observers that in a population of military age between 19 and 45 about 50 per cent. would be found disqualified. This is startling and, if true, calls for radical reform in the hygienic education of the people in the overcoming of much preventable physical deficiency. In the words of Kipling:

"It ain't the individual,  
Nor the army as a whole,  
But the everlastin' team work  
Of every bloomin' soul."

#### EPIDEMIC MENINGITIS.\*

By CARL D. SAWYER, M. D.,  
Providence, R. I.

Epidemic meningitis has been quite prevalent in the army camps of Europe during the period of the war and has been the cause of many deaths. With the establishment of cantonments in this country it has been quite prevalent here. Some very interesting work has been done on the diagnosis and treatment of the disease and as a result quite a few new observations of importance have been made.

The meningococcus is unknown in nature aside from the human host. Its presence in a community is not due so much to active cases as it is to chronic carriers of the disease. Since these carriers are apt to be unsuspected, it fol-

\*Read before the Medical Research Club, March 8, 1918

lows that they are the agencies by which the infection is propagated. This situation is bad enough in ordinary times, but in war time, with the association of men in camps, it becomes serious. These young soldiers are at the susceptible age and by the necessary close contact with others among whom are carriers the inevitable result is that many contract the disease.

*Mode of Infection:* All agree that the primary seat of infection is the nasopharynx. The meningococci also leave the body by way of the secretions of the nasopharynx. When the meningococci are once implanted on the mucous membrane of the nasopharynx they probably multiply there. There is some difference of opinion as to how they reach the meninges. Dr. Flexner says the organisms may pass directly to the nervous system by way of the lymphatics alongside the olfactory nerves or by way of the blood. He believes, however, it is usually by the lymphatics.

Major Herrick of the United States Army believes the disease is not primarily a meningitis, but that it is a generalized systemic infection—a sepsis—with possible secondary involvement of meninges, joints, pericardium, endocardium, testicles, conjunctivae, sclera, pleura, lungs, from all of which regions, in addition to the tonsils and pharynx, the meningococci have been isolated. In many of his cases the systemic symptoms appeared one to three days before the involvement of the meninges. In 75 per cent. of his cases a petechial rash appeared very early and was the first valuable sign.

Major Medlar, United States Army, also believes that the epidemic type of meningitis, like all cases of meningitis except the traumatic types and those due to abscesses, is hematogenous.

Thomsen and Wulff of Copenhagen in December, 1917, succeeded in getting a number of positive blood cultures early in the disease. They also cultivated them from the petechiae. In their series of 42 cases all had sore throats. Their conclusions were that the majority of cases must be regarded as metastatic complications of a primary infection of the blood. They also believe that the meningococci vary in virulence at different periods and that the virulence is increased by repeated passage through one nasopharynx after another. Their observations seem to indicate that the meningococci have greater virulence during the seasons when people

are housed most and are most subject to colds. At other seasons the organisms live as saprophytes, and if the hosts develop a catarrhal condition they spread the organisms in speaking, coughing and sneezing, and their virulence is increased by being planted on another nasopharynx. This seems to explain why there may be long absences of the disease, followed, perhaps, by epidemics; also why carriers rarely develop meningitis and why chronic carriers seldom give rise directly to meningitis cases.

*Carriers and Methods of Detection:* Two classes of persons may have the meningococcus; first, persons suffering from epidemic meningitis; second, healthy carriers. The first is of less danger than the second because he is confined to his bed. The healthy carriers, being unsuspected, move about and are therefore a menace, and when introduced into a group of susceptible ages a certain number become contaminated. A variable number of these become infected and develop meningitis, but a larger number become temporary carriers or more enduring or chronic carriers. The number of carriers produced exceeds the number of cases of infection. These carriers are classed as "contact" and "non-contact" carriers, being distinguished according as they have arisen from a known previous carrier or from a case of meningitis or without such known association.

From figures obtainable it appears that about 2 per cent. of a general community are carriers. But among contacts 5 per cent. to 10 per cent. are carriers.

The duration of this carrier stage naturally varies. Flack has found that about 2 per cent. of cases become clear in a two-week period, 52 per cent. in a four-week period and 5 per cent. in a twelve-week period. Duration has lasted twelve to fifteen months, with eventual disappearance of the organisms. Sunshine and clear weather tend to cause them to clear earlier, while tonsillitis and catarrhal inflammations tend to prolong the carrier stage.

For the detection of these carriers a special technic has been devised. A West tube is the instrument which may be used to obtain the secretions from the nasopharynx. The secretions are planted on serum agar plates. Colonies from these plates are transferred to sheep serum agar slants and incubated for another sixteen to twenty hours. These cultures are subjected to microscopic examination, agglutination tests and

fermentative effects on sugars. The agglutination test is the final test.

*Types of Meningococci:* The meningococcus is not a consistent species, but consists of several closely related varieties. Culturally these several members are identical, but differ immunologically.

Dopter in 1909 was the first to discover that the prevailing type (called normal or regular) differed from a second type, called by him para. An immune serum prepared with normal cultures contains agglutinin and other antibodies for its own type and little for the other type. Since that time English bacteriologists have classified the meningococci into four types, I, II, III and IV. Type I corresponds to the para and type II to the normal or the regular meningococcus. Types III and IV conform to the more common intermediates. There seems to be, therefore, from immunologic studies two fixed types and certain less fixed ones, any one of which may cause epidemic meningitis.

To successfully fight the disease a polyvalent antimeningococcic serum must be used. This serum must contain antibodies of the fixed types and for as many of the intermediates as may be available.

It has also been shown that the types of meningococci which occur in the cerebro-spinal fluid correspond with those found in the nasopharynx. It has been shown, too, that a carrier which gives rise to other carriers results in that identical type of meningococcus in all, and that the occupation of the mucous membrane by one type renders the contamination by a second type very infrequent.

*Treatment of Carriers:* Since carriers are now recognized as the sole source of infection, they are the ones who require special measures to prevent the spread of the disease. Isolation naturally is necessary. Attempts have been made to immunize them by means of vaccines, but absolutely without success. Several antiseptic chemicals have been applied to the nasopharynx by swabbing, douching, spraying and vaporization. Dunham and Dakin have devised a solution of dichloramin-T in oil to be applied by means of a hand spray which seem to be about the most efficient.

In this review of the literature a number of interesting things were noted, especially some diagnostic points, which seem worth mention-

ing. The first is the petechial exanthem which Herrick found very early. To be sure, this has been noted before, hence the old name, spotted fever, but as has been stated heretofore, Herrick found this rash in about 75 per cent. of his cases as the earliest sign. It appeared first on the deltoid regions, hips, trunk, extremities, mucous membranes and face. The purpura of his fulminating cases did not appear to originate in these petechiae, but were apparently a separate lesion. A minority of the cases, however, showed little or no rash.

Another thing of interest is the fact that the meningococcus can usually be recovered from the spinal fluid at the first or second lumbar puncture, even six to thirty-six hours before the characteristic clinical picture develops, or even before the spinal fluid becomes cloudy or shows an increase in cells.

At this stage the fluid may be perfectly clear, have a normal cell count and may or may not show globulin, yet when centrifugalized and strained a very few meningococci may be found. In doubtful cases it seems advisable to repeat the spinal puncture at intervals of three to six hours in order to drain the meningococci from the brain down into the spinal canal. By so doing a second puncture may show pus and organisms. It has been suggested that this observation indicates that the meningeal infection begins within the skull and the spinal meninges become infected later by extension.

Another point of interest is the fact that blood cultures made early show surprisingly often the presence of meningococci in the blood. These organisms are by no means easy to grow and require special media, hence negative results must be expected in a certain number of cases.

*Treatment:* The treatment of ordinary cases may be passed over because the method is unchanged. But there is one form of treatment which, in some cases, has given excellent results and should be mentioned. It is the intravenous use of serum. Herrick has found that in the stage of sepsis before meningitis has developed the routine administration of serum intravenously is very efficacious. It is given in doses of 20 to 60 c.c. every 24 hours for two to three days. He believes it should be given before intraspinal treatment in such cases; in fact, that it is best to postpone intraspinal treatment until the fluid becomes cloudy.



## CLINICAL DEPARTMENT

## A CASE OF SIMULTANEOUS FRACTURE OF SIX LONG BONES.\*

By ROLAND HAMMOND, M. D.,  
Providence, R. I.

J. H., age 12, while running across a street, January 20, 1917, was struck by an automobile truck and knocked down. She was brought to the Memorial Hospital, Pawtucket, where it was found that she had sustained simple fractures of the middle of the humerus, radius, ulna, femur, and at the junction of the middle and lower thirds of the tibia and fibula. All these fractures were on the left side of the

leg bones showed that the positions of various fractures were not entirely satisfactory, and Dr. Frederick V. Hussey very kindly asked me to assume charge of the case.

On February 3 an adhesive plaster extension was applied to the leg and fifteen pounds weight added. A counter extension from the groin to the head of the bed was also applied and ten pounds weight added. In a similar manner an extension was applied to the arm, which was abducted until it was nearly at a right angle to the body. A counter extension was applied from the axilla to the head of the bed. Coaptation splints were placed to control the fragments of the femur and humerus, and a posterior wire splint was applied to the



FIG. 1. Showing fibrous union between radius and ulna at point of fracture.

body. There were also multiple contusions of various parts of the body, and a general condition of shock.

On January 25 a plaster spica was applied to the leg under ether, and on January 27 a similar spica was applied to the arm under ether. X-ray examination of both arm and

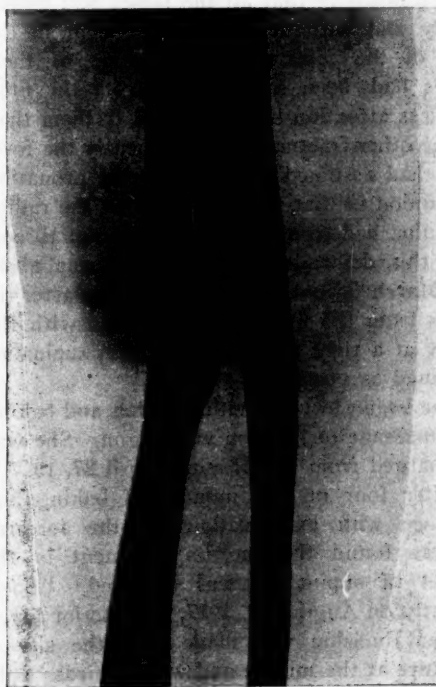


FIG. 2. Condition after operation in which fibrous union was severed and forearm held in supination during recovery.

leg in an attempt to control the fragments of the tibia and fibula, and to keep the foot at a right angle to the leg. The foot of the bed was elevated. Four days later six pounds more weight were added to the leg extension. These various measures served to control the position of the fragments and to bring the limbs down to length, except in the case of

\*Read before The Providence Medical Association, January 7, 1918

the leg. Here the fragments of the tibia and fibula could not be controlled and the lower leg and foot were gradually forced backward, producing a forward bowing at the site of fracture.

On February 15, the patient was etherized on a Hawley table, the leg pulled down to length, and the deformity of the tibia and fibula corrected. A plaster cast was applied from the toes to above the knee, with the foot at a right angle to the leg. Windows were cut over both malleoli through which the extension straps on the leg were passed. Extension and counter extension on both arm and leg were continued in bed until March 2, when all apparatus was omitted.

It was found that all the bones had united firmly and without deformity, except in the case of the forearm. The position of these bones had been satisfactory from the first, and less attention had been paid to them than to the other fractures. Consequently the forearm had assumed the position of pronation and union in that position between the radius and ulna had resulted. In an attempt to correct this deformity nitrous oxide was given on March 5, and the arm put in plaster of Paris from the fingers to the axilla with the elbow at a right angle and as much supination obtained as possible.

She began to walk with crutches and baking and massage of the arm was begun. She was discharged from the hospital April 27, 1917.

After four or five months of baking and massage with manipulations of the forearm, it was found that no improvement in the power of supination was obtained. Consequently on August 22, 1917, an anterior longitudinal incision was made over the site of fracture at the middle and upper thirds of the forearm. Fibrous union between the radius and ulna was found. This was severed, the bones were separated, and a plaster cast applied from the fingers to the axilla with the elbow at a right angle and the forearm in complete supination. The patient was discharged from the hospital September 8 in plaster.

She now presents 3-4 inch shortening of the left leg which is compensated for in the pelvis, since no curvature of the spine is present. The gait shows no evidence of a limp. Supination

is practically as complete as in the normal forearm, and there remains only a slight bowing of the forearm which will disappear with further growth. Except for these slight imperfections the result otherwise is satisfactory in every way.

#### REPORT OF THE FIRST CASE OF PELLAGRA IN 1918.\*

By HENRY A. JONES, M. D.,  
Howard, R. I.

Among the diseases caused by defective nutrition are scurvy from preserved food, beriberi from polished rice, and peripheral neuritis from canned or salt meat. Yet another disease may possibly have to be placed in this category. It is an old belief that pellagra with its train of cutaneous and nervous diseases is associated with a corn diet. This is debated. It is a curious coincidence that in the United States with its perfect milling systems the vitamins are removed from the flour to a greater extent than in Italy, and whereas the milder chronic type of the disease is common in Italy, the acute form is frequent in the United States. The diet should contain fresh vegetables, milk, meat to afford sufficient vitamins.

Axel Horst of Christiania found that fowls and pigeons showed progressive paralysis similar to the ship beriberi among the sailors of Norway.

Braddon in the Malay peninsula stated that beriberi was due to an exclusive rice diet and attacks those who fed upon the diet of polished rice.

Fraser and Stanton, acting on this suggestion, tried this on prisoners and could arrest the disease by feeding them the bran made from the hulls of the rice. Even the alcoholic extract from this bran cured the disease. They found that this something was neither a proteid, fat nor carbohydrate, and they found that there was another necessary element to preserve life. It is not even an enzyme, but is effective when present in the most minute quantities.

This new food factor has been named vitamin by Funk. With it and the addition of  $C_{24}H_{40}O_6N_2$ , he has arrested the paralysis found in pigeons fed on an exclusive diet.

M. L., widow, 52 years old, the mother of three children. Has been moral and temperate in every respect. Mill worker for eleven years and kept her own home. Left mill work because her feet began to swell and became tense and shining. No regularity about this swelling. No other definite symptoms at that time. After leaving mill went to work as a charwoman by the day. Always indoors.

\*Read before The Providence Medical Association, May 6, 1918

Diet. Morning and evening meals at home. This would consist of a general diet with the exception of an excess of cornmeal in the form of Johnnycakes every morning and very often during the day, and also was very fond of cornmeal pudding. Her method of using milk was always to use condensed milk, never fresh milk.

For two years she has been rooming alone, boarding herself, getting her meals rather scantily, and on account of the increasing price of all commodities she used more and more of cornmeal because, as she tersely puts it, "It is all I could afford to buy." So far for the diet and general mode of living.

Medical History. (1) The history of swollen limbs causing her to seek a different occupation.

Previous History. (2) Went to Rhode Island Hospital in ambulance from own room three years ago for a shock. Blood test showed chronic malaria. Treatment consisted of bakes of the left leg for three weeks. Menopause three years ago, when she had severe hemorrhages. This kept up about one year. Stopped work on account of weakness. Consulted a physician, who informed her she was "run down and needed rest." She gave as symptoms: (a) Loss of appetite. (b) Lack of sleep. (c) Nervousness. (d) Loss of flesh. Never had a headache. No bowel trouble. Visited a physician twice. After this until her admittance to the State Infirmary she sat around the house.

Previous diagnosis made on account of mental condition: Climatic insanity.

Symptoms prominent since admission: (1) Mental apathy with fixed or stationary depression, loss of memory with approaching dementia. (2) Physical lethargy. Listless and weak. (3) Gastric disturbance. Vomiting and loss of appetite, weak and rapid pulse. (4) Cutaneous eruptions on back of hands about April 1 and later manifestation about chin and nose.

Diagnosis: Pellagra. Cause: Improper dieting. Treatment: Tonics, strychnine and arsenic. Milk and vegetables.

#### THE SUPREME COURT DECISION ON THE CORPORATE RIGHTS OF THE AMERICAN MEDICAL ASSOCIATION.

In 1910 the state's attorney of Cook County (Chicago) was petitioned to institute "quo warranto" proceedings against the American Medical Association on the grounds that the Association's affairs were being conducted illegally in that its officers were elected at annual sessions held outside of the state of Illinois. The state's attorney refused to take action in the matter, and later the attorney general of the state, who was appealed to, also refused to act. January 5, 1911, mandamus proceedings were begun in the Circuit Court of Cook County, Illinois, to compel the

state's attorney to initiate the quo warranto action which he had declined to institute. Until December 20, 1915, the issue was between the parties asking for the "mandamus" and the state's attorney of Cook County, Illinois; the point at issue being the technical one as to whether the state's attorney was compelled to act or had discretionary authority in the matter. The case went through the lower courts and finally was carried to the Supreme Court of Illinois, which in December, 1915, refused to hear arguments on the merits of the cause as it related to the American Medical Association, but ordered the Circuit Court to take up the original quo warranto proceedings designed to raise the question whether or not Illinois corporations "not for profit" are compelled to hold their elections and conduct their business within the confines of the state. Up to this point the American Medical Association was not technically interested in the controversy; now, however, it became a party in the action. Quo warranto proceedings against the members of the Board of Trustees were instituted in the Circuit Court of Cook County, Illinois, which after trial rendered a decision favorable to the Association. The case was then carried to the Appellate Court of Illinois, which confirmed the decision of the Circuit Court. An appeal was finally made to the Supreme Court of Illinois, which last week (April 16) rendered its decision, settling the question. This decision is entirely satisfactory so far as the Association is concerned. One paragraph of the opinion reads:

"It seems reasonably to follow that if a corporation not organized for pecuniary profit may hold meetings at stated times outside of the state of Illinois, composed of delegates selected by the constituent associations, for the transaction of business of the corporation, it is not unlawful to authorize and provide for the election by said house of delegates of trustees of the corporation. The American Medical Association was organized solely for the purpose of the advancement of medical science. Its purpose was to improve methods for the treatment and prevention of diseases of the human race. Its usefulness for these purposes would be seriously interfered with, if not absolutely destroyed, if it could not provide for the election of trustees from the most efficient men in the Association throughout the United States, by delegates selected by the constituent associations from the various states in the Union. Such authority to the house of delegates is conferred by the by-laws and is not in conflict with or prohibited by the constitution or laws of Illinois relating to corporations not for pecuniary profit."

The decision is important not only to the American Medical Association, but also to all organizations incorporated under the law of Illinois—in fact, of any state—governing corporations "not for profit."—*Jour. A. M. A.*

# THE RHODE ISLAND MEDICAL JOURNAL

Owned and Published by the Rhode Island Medical Society  
Issued Monthly under the direction of the Publication Committee

ROLAND HAMMOND, M.D., *Editor*  
249 Thayer Street, Providence, R. I.

J. F. HAWKINS, M.D.  
*Business Manager*  
114 Westminster Street  
Providence, R. I.

ALEX M. BURGESS, M.D.  
JOHN E. DONLEY, M.D.  
J. W. LEECH, M.D.  
F. T. ROGERS, M.D. } *Associate Editors*

*Committee on Publication*

ROLAND HAMMOND, M.D., *Chairman*  
J. F. HAWKINS, M.D.  
W. A. RISK, M.D.  
JOHN CHAMPLIN, M.D.  
J. W. LEECH, M.D.

Editorial Correspondence, Books for Review and Exchanges should be addressed to the Editor; Advertising Correspondence to the Business Manager.

Advertising matter must be received by the 15th of the month preceding date of issue.

Advertising rates furnished upon application, to the business manager, J. F. Hawkins, M.D., 114 Westminster Street, Providence, R. I.

SUBSCRIPTION PRICE, \$2.00 PER ANNUM. SINGLE COPIES, 25 CENTS.  
Entered at Providence, R. I. Post Office as Second-class Matter.

## RHODE ISLAND MEDICAL SOCIETY

Meets the first Thursday in September, December, March and June

JOHN CHAMPLIN	<i>President</i>	Westerly
GARDNER T. SWARTS	<i>1st Vice-President</i>	Providence
JOHN M. PETERS	<i>2d Vice-President</i>	Providence
JAMES W. LEECH	<i>Secretary</i>	Providence
W. A. RISK	<i>Treasurer</i>	Providence

### DISTRICT SOCIETIES

KENT		
Meets the second Thursday in each month		
H. BARTON BRYER	<i>President</i>	Natick
JAMES M. BODWELL	<i>Secretary</i>	Phenix
NEWPORT		
Meets the third Thursday in each month		
EDWARD V. MURPHY	<i>President</i>	Newport
A. CHACE SANFORD	<i>Secretary</i>	Newport

PAWTUCKET		
Meets the third Thursday in each month excepting July and August		
ARTHUR H. MERDINYAN	<i>President</i>	Central Falls
CONRAD E. THIBODEAU	<i>Secretary</i>	Pawtucket

PROVIDENCE		
Meets the first Monday in each month excepting July, August and September		
WILLIAM F. FLANAGAN	<i>President</i>	Providence
CHARLES O. COOKE	<i>Secretary</i>	Providence

WASHINGTON		
Meets the second Thursday in January, April, July and October		
A. B. BRIGGS	<i>President</i>	Ashaway
W. A. HILLARD	<i>Secretary</i>	Westerly

WOONSOCKET		
Meets the second Thursday in each month excepting July and August		
EDWARD L. MYERS	<i>President</i>	Woonsocket
E. F. HAMLIN	<i>Secretary</i>	Slatersville

**Section on Surgery**—2d Wednesday in each month, Dr. F. G. Phillips, Chairman Dr. Peter P. Chase, Secretary and Treasurer.  
**Section on Diseases of Children**—3d Tuesday in each month, Dr. Henry E. Utter, Chairman; Dr. J. S. Kelley, Secretary and Treasurer.

**Section on Gynecology and Obstetrics**—3d Wednesday in each month, Dr. C. W. Higgins, Chairman; Dr. E. S. Brackett, Secretary and Treasurer.

**Section on Medicine**—4th Tuesday in each month, Dr. D. Frank Gray, Chairman; Dr. C. W. Skelton, Secretary and Treasurer.

**R. I. Ophthalmological and Otolological Society**—2d Thursday—October, December, February, April and Annual at call of President, Dr. Harlan P. Abbott, President; Dr. C. J. Astle, Secretary-Treasurer.

## NOTICE

The House of Delegates having voted that the dues shall be \$10.00 for 1918, the Treasurer desires to call the members' attention to Article IV Sec. 6 of the By-Laws: "Every Fellow shall annually contribute the Annual dues and the same shall be due and payable to the Treasurer, January first of each year."

## EDITORIALS

### SCIENTIFIC MEDICINE AND THE WAR.

In this number of the JOURNAL appears an article which represents the experience gained from examination of registrants in the recent draft. It is the first attempt in this state to utilize for scientific purposes the wealth of material furnished by this remarkable experiment in democracy, and as such is highly commendable. Draft examinations present unique features entirely different from the examinations in civil practice. In the latter case the patient is only too willing in most instances to afford the physician every opportunity of obtaining a full history



and a thorough examination. He wishes to aid the physician in every way. With the drafted men, the conditions are exactly the reverse. The general tendency is to endeavor to escape the necessity of serving as cannon fodder, although there are fortunately many notable exceptions to this rule. Consequently the examiner is put upon his mettle, and is forced to draw his conclusions largely from the physical examination and the general survey of the man in question. This is the first examination of the young manhood of the nation as a whole. College students, applicants for the army or militia, and, to a certain extent, industrial workers, have been examined in the mass, but the conclusions drawn, if any, have never been placed before the medical profession in a satisfactory manner. We shall know much more about the health of our men as a result of this war. With the improved hygiene in working and living conditions which will inevitably follow, the efficiency, health and happiness of our people will be correspondingly improved.

The great strides already made in the treatment of injuries and of disease are too well known to bear comment. It is a trite saying that the war has speeded up activities and invention in all lines of endeavor. It is particularly true in the case of medicine and surgery. The treatment of many injuries and diseases has already been revolutionized, and no one can predict the progress which will have been made by the end of the war. The interval elapsing between the end of the medical or surgical treatment and the resumption of work by the patient has always been one of the loose ends of our art. It has never been anyone's business to help the invalid to come back. Now with the establishment of reconstruction centres, each having a physiotherapeutic plant for treatment, curative workshops and trade schools, and with the co-operation of federal employment bureaus, the man will be guided and taught until he is self-supporting. It is encouraging to feel that the cripples of the present war will not be allowed to drift and to fill our institutions with derelicts as in previous wars, but will become respectable and self-supporting citizens.

---

#### THE LIFE EXTENSION INSTITUTE.

The Doctor is accustomed to competition, if one may thus dignify the advertising methods of

the quack and charlatan, but it is not often that there is enlisted as an active competitor such eminent men as an ex-president of the United States and a professor of political economy of a great university. It is safe to assume that William H. Taft and Irving Fisher have not allowed the use of their names in the advertisement of the "Life Extension Institute" without a knowledge of what it implies to the average reader of a newspaper, and of course they are familiar with the aims and purpose of the "Institute." In the event that they are ignorant of the methods used, or that their names are used without authority, they should see to it that their reputation and influence are not capitalized for purely commercial interests. If their names are used with authority—, but let us hope they are not.

In a recent issue of the *New York Times* this is what is claimed: "The Institute's system of examination and reports was formulated in consultation with the members of the Hygiene Reference Board (whatever this may be), men who have for years been engaged in analysing human lives and the influences that impair them, and the system has been standardized from the Institute's wide experience in examining many thousands of individuals. It makes no difference where you live. The Life Extension Institute comes to you wherever you are. It has an experienced staff of examining and reviewing physicians in its main office in New York, a branch office in Chicago, and a staff of more than 5000 physicians throughout the United States and Canada.

"The cost of membership in the Life Extension Institute is low, because of its humanitarian character and national ideals.

"Examinations of subscribers who live in New York City or vicinity are made at the head office of the Institute. Woman physicians are available in the main office for the examination of women members who prefer them.

"Membership entitles you to the following:

"1. A complete bodily survey which includes the Institute's Standard Physical Examination of the eyes, ears, nose, throat, mouth, teeth, tongue, lungs, heart, circulation, skin, glands, stomach, liver, abdominal organs and general bodily condition. Also examination for evidence of rupture, varicose veins, faulty posture, flat-foot, spinal curvature, deformities and asymmetries—test of the vision and hearing and of the brain

and nervous system for paresis, locomotor ataxia and other central nervous afflictions or nervous instability—height, weight, chest and abdominal measurements—blood pressure by the Auscultatory Method.

"2. Four chemic and microscopic examinations of the urine a year, by means of which a close watch is kept upon your kidneys in relation to your general physical condition.

"3. Hemoglobin Blood Test for anemia.

"4. Confidential detailed reports of your exact physical condition with a personal letter from one of our reviewing physicians commenting on your whole case, together with special health literature covering the impairments noted in the report.

"5. Suggestions as to proper diet with appropriate diet lists.

"6. Instructions covering appropriate exercises with diagrams.

"7. Keep-Well Bulletins covering your particular needs.

"8. The Monthly Health Journal of the Institute entitled 'How to Live.'

In short, the Institute proposes to usurp the functions and duties of the physician, and, if the statements are true, and they have 5,000 physicians enrolled as experts, there must be some in Rhode Island. Do you know them, or did you ever hear of them? Is it true that they number among their consulting staff, as they say they do, the Surgeon-General of the Army, Navy, and Public Health Service, several ex-presidents of the American Medical Association and Commissioners of Health, and do they ever submit to them matters of scientific policy and educational material as they claim to do?

If your opinion is asked regarding the Life Extension Institute, recall the experience of a prominent physician who was routed out of bed to respond to the question, "Can you tell me where I can find a good doctor?"

#### THE IRREGULAR CULTS IN THE WAR.

It is a source of satisfaction to all physicians that the health of our troops is under the care of the regular members of the profession. On the other hand, there is keen disappointment in the ranks of the osteopaths, chiropractics, Chris-

tian Scientists, and the other cults too numerous to mention. They had hoped to be invited to administer their particular form of therapy in some part of the army, presumably in base hospitals at cantonments, as they would hardly expect to be allowed to care for the wounded at the front. Of course, the Surgeon-General has been charged with favoritism in allowing only those holding the degree of M. D. to become medical officers. The term of "medical officer," by the way, is a fine one. It does not oblige a man to consider himself a surgeon whether or no, and it makes no invidious distinction between the surgeon and the physician. The Surgeon-General is not showing favoritism. He is limiting his choice to the medical profession as is incumbent upon him. This is not a time for trying out new systems of treatment. It is a time to rely upon that system of medicine which has proved the standard for countless ages, a system which has never wavered from the scientific principles and high ideals of Hippocrates, although it has halted at times over some fads of its own. If a man is not feeling well, he may accept the advice of friends or the drug clerk, but when he is really ill, he calls a doctor. When the nation has its back to the wall, it calls on the regular medical profession, as it always has done in the past, and will continue to do in the future.

There is another insinuation which would be too absurd for consideration were it not for the many anxious parents whose sons are exposed to camp diseases. The anti-vivisectionists are claiming that the great prevalence of camp pneumonia and bronchitis is due to the fact that the boys have received inoculation with typhoid and paratyphoid vaccines. Arguments and statistics showing that the great scourge of previous wars—typhoid fever—has been practically wiped out in modern warfare by such prophylaxis are of no avail with this class of citizen. Scientific facts do not appeal to him. Here is an opportunity for all physicians to allay the fears of anxious parents whose sons are serving their country, by explaining the true facts regarding camp diseases, and to point out the great care taken by the medical corps to preserve the health of our troops. In no previous war has the medical corps been spurred on to greater action, and never has it achieved such splendid results. A finer medicine and surgery awaits the dawn of peace.

### MORE MEDICAL OFFICERS.

Every physician by now must be aware of the recent urgent call from the Surgeon-General's office for 7,000 more medical officers. There are commissioned to date a little over 18,000 physicians in the Medical Reserve Corps. Two facts account for this unusually heavy call for more physicians. In the first place, the original estimate of seven medical officers per 1,000 of troops has been found today to be too low, and the ratio of ten medical officers per 1,000 troops is found to be necessary. Secondly, the weeding out process of physicians who are unfit for various reasons for military service is now at full tide, as sufficient time has elapsed to sift the wheat from the chaff, and in one week in April the Surgeon-General's office was faced with the disquieting information of 60 new enlistments against 70 discharges, a net loss of 10 medical officers in one week. Obviously, something must be done, and that something is that there must be a notable increase in the number of medical enlistments if our fighting boys are to have the trained medical care that is their right.

Rhode Island has done as well as other communities—the low rank among the states in percentage of enlistments in relation to medical population being due to split decimals of percentage rather than to any gross difference from her sister states. But we have not done enough. We must furnish *now* at least 50 more medical officers as our quota.

The experience of Rhode Island is that of the states all over the Union—the enlistments are coming from the two extremes of the medical profession, namely, those up to 31 years of age and secondly those over 45 years of age. It is no aspersion upon the patriotism of the first group to note that their services would be demanded anyway under the Selective Service Act. Rather it is a reproach that the men between these two ages are not coming forward for service. You men between 30 and 45 years, look this thing in the face! Your country calls you. Your young brother is in the trenches, and are you going to deny him your help because you "have just got a practice going in good shape?" Everyone of us must take this question right home to ourselves and earnestly and honestly decide where his duty lies. No matter what pressure is brought to bear—and it will be and soon—every man must fearlessly face the decision in his own heart.

Out of a total medical population of 772, Rhode Island has commissioned 128. But at a conservative estimate there are 350 men under the eligible age of 55 years. Can anyone doubt that the Nation's call for 50 more doctors from Rhode Island will meet with anything less than a prompt response?

### A MEDICAL SURVEY.

The American Medical Association will shortly publish a very thorough and accurate survey of the medical resources of the nation by states and counties which will serve as a basis to compute the quota of physicians each section should furnish for the armed forces of the country. This survey will cover the population—civil and medical—the names of men holding commissions, those who have applied for commissions but have been rejected, and those who have been discharged, and those men over 55 years of age.

The decision as to which men within the age of eligibility should apply for commissions and which should remain for indispensable civilian needs will be a grave one, and the officers of the State and District Societies are urged to give the fullest and promptest support to the "drive" which is to be launched for the purpose of increasing medical enlistments.

## SOCIETIES

### DISTRICT SOCIETIES

#### PROVIDENCE MEDICAL ASSOCIATION.

May 6, 1918.

The regular monthly meeting of the Providence Medical Association was held at the Medical Library on May 6, 1918. The meeting was called to order by the President, Dr. William F. Flanagan, at 9 p. m. In the absence of the Secretary, Dr. F. M. Adams was appointed Secretary pro tem. There were present at the meeting 33 members. The records of the preceding meeting were read and approved. A communication was read from the Providence Housewives' League inviting the members to a lecture by Dr. E. V. McCollum of Johns Hopkins University on May 17, 1918.

Dr. Dennis C. O'Leary and Dr. Ransom H. Sartwell, having been approved by the Standing Committee, were elected members of the Association.

The first paper of the evening, entitled "Some

Cardio-Vascular Conditions in Connection with Advisory Draft Board Examinations," was read by Dr. George S. Mathews. The paper was discussed by Drs. Mowry, Gray, Burgess, Adams and H. A. Jones.

The second paper, entitled "State Hospital for Mental Diseases with Lantern Slides," was read informally by Dr. Arthur H. Harrington.

Dr. H. A. Jones presented a case of pellagra, giving a detailed history of the case.

The meeting adjourned at 10:45 p. m. A collation was served.

FRANK M. ADAMS, *Secretary, Pro. Tem.*

#### WASHINGTON COUNTY MEDICAL SOCIETY.

The quarterly meeting of The Washington County Medical Society was held at the Colonial Club, Westerly, April 11, 1918.

Prior to the business session the Society was entertained by the President, Dr. A. B. Briggs, at the Princess Theatre. Such entertainment consisted of moving pictures depicting an operation for Exophthalmic Goitre, by Albert J. Ochsner, M. D., and an operation for Complete Perineal Laceration, by Edward J. Ill, M. D.

The Committee on Lodge and Contract Work reported progress and was continued.

The Child Welfare Movement was presented, but it was thought best to leave the matter in the hands of the Westerly Physicians' Association.

Luncheon at the Club followed adjournment.

W. A. HILLARD, M. D., *Secretary.*

#### WOONSOCKET DISTRICT SOCIETY.

The regular monthly meeting of the Woonsocket District Medical Society was held April 18, 1918, at the office of Dr. J. J. Baxter. The meeting was well attended. A general discussion took place concerning various matters of interest to the society.

It was voted to hold the next meeting at the Woonsocket Hospital, and a committee consisting of Drs. E. D. Clark, W. F. Barry and W. C. Rocheleau was appointed to procure a speaker for the occasion. Adjourned 10:30 p. m.

E. F. HAMLIN, *Secretary.*

#### KENT COUNTY MEDICAL SOCIETY.

The regular meeting of the Kent County Medical Society was held in the rooms of the

Nurses' Association at River Point, R. I., April 18, 1918, Dr. H. Barton Bryer presiding. Minutes of the last meeting read and approved. Bill H. 651, introduced by Dr. O'Meara of Providence providing for the appointment of a commission to investigate the use of habit-forming drugs, and Bill H. 679, introduced by Dr. O'Meara of Providence, requesting the State Board of Health to consider the advisability of establishing medical reciprocity, were discussed and a resolution favoring them was ordered sent to the proper officials by the Secretary. Dr. Frank M. Adams of Providence read a paper entitled "Nose and Throat Findings in Some Cases of Endocarditis." This report was based largely upon his findings in examining recruits for the United States Army. A vote of thanks was extended to Dr. Adams. Voted to adjourn.

JAMES M. BODWELL, *Secretary.*

## MISCELLANEOUS

### MOBILIZATION OF THE RHODE ISLAND HOSPITAL UNIT.

Nine physicians in the Navy Base Hospital No. 4, formed in Rhode Island some time ago under direction of Dr. George A. Matteson, have been ordered into active service and left May 15 for Newport for a course of preliminary instruction. Nine others are expected to go within a short time, and the 86 civilian members of the unit were ordered to report at Newport May 20.

The physicians now at Newport are Lucius C. Kingman, William H. Buffum, Alex M. Burgess, Paul Cook, Elihu S. Wing, Henry L. Johnson of Westerly, Frank H. Mathews, Leon S. Gilpatrick and Albert A. Barrows. The nine physicians who are to go later are Halsey DeWolf, Roland Hammond, Frederic V. Hussey, Joseph C. O'Connell, Lewis B. Porter, Clinton S. Westcott, George A. Matteson, William P. Buffum, Jr., and George C. Eckert of Newport. Dr. Eckert is now at sea and may not be able to go with the unit. George T. Holt, D. D. S., will be dental surgeon with the unit.

Following are the names of the members of the unit, with the branch of the service to which they have been assigned and their ranks:

George A. Matteson, Lieutenant Commander, Director and Chief of Surgical Service; Halsey DeWolf, Lieutenant Commander, Chief of Medical Service.



Lieutenants, Senior Grade—Lucius C. Kingman, surgical service; Roland Hammond, orthopedic surgeon and roentgenologist; Lewis B. Porter, eye, ear, nose and throat surgeon; Fred-eric V. Hussey, Joseph C. O'Connell, Albert A. Barrows, surgical service; Clinton S. Westcott and William H. Buffum, medical service.

Lieutenants, Junior Grade—Alex M. Burgess and William P. Buffum, Jr., medical service; George H. Eckert, Elihu H. Wing, Paul Cook, Henry L. Johnson, Frank H. Mathews and George T. Holt, D. D. S.

Hospital Apprentices—Edwin Anderson, Morris H. Atkins, Robert Aylesworth, Fred Barker, George H. Bristol, Linton L. Brown, Harry V. Byrne, Peter R. Campbell, Edwin L. Carlson, John R. Cheetham, Byron R. Cole, George N. Dunbar, Joseph H. Fagan, Wilfred H. Hammill, Albert C. Holden, George L. Howe, Williamson Howe, Walter F. Joslin, William McK. Kelso, Joseph T. Kershaw, James J. Lavery, Clifford L. Lloyd, William H. McKenna, John H. Magee, Harry B. Murray, John W. Moore, Robert Nelson, Harry A. Noel, Cleophas Noel, Fred E. O'Connell, Herbert W. Pecker, Charles H. Philbrick, George C. Sims, Rudolph Swanson, James F. Sweeney, Edmund J. Tanner, Fred Walker, Howard E. Williams, Sidney W. Wray, Harvey E. Wellman.

Petty Officers—George F. Bliven, paymaster clerk; Charles J. DeCromer, commissary steward; Steven E. C. Kendrick, chief yeoman; William J. Hammond, yeoman, first class; Francis D. O'Connell, yeoman, second class; Carl A. Knowles, yeoman, first class; Manuel Bloom, yeoman, second class; Henry H. Aldrich, electrician, third class; Harold E. Peck, electrician, third class; John Rhodes, plumber; Thomas Clarke, plumber; Wilfred Ducharme and Norman Thorpe, carpenters; Alfred Buckley, Jr., and Cyril Henius, machinists' mates.

Cooks—John Marcado, Peter C. Thorne, Christopher T. Nolan, James Cameron, Jr., Frank D. Hurley, William F. Durvin, William H. Shaw, Robert C. Calvin, George A. Carey, Joseph E. Donahue, Peter A. Carr, Lawrence H. Smith and M. C. Montneau.

Mess Attendants—William Buchart, William Cashin, Thomas A. Corbett, Eugene S. Duffy, James J. Duffy, Edward Kilduff, Philip Lavery, Charles McPhillips, Edward Madden, Archibald M. Morrison, Francis H. Norton, Ralph L. Smith, Thomas Rhodes, W. H. Ward, Thomas

J. Welch, Russell O'Neal, John P. Ormand and Ralph F. Mayberry.

#### HONOR ROLL.

Lieut. Joseph W. Bannon, M. R. C., U. S. A.  
Capt. Remington P. Capwell, M. R. C., U. S. A.  
Capt. Frank A. Fearney, M. R. C., U. S. A.  
Capt. John B. Ferguson, M. R. C., U. S. A.  
Capt. Winthrop A. Risk, M. R. C., U. S. A.

#### AMERICAN PROCTOLOGIC SOCIETY.

Owing to conditions brought about by the war, the American Proctologic Society has decided not to hold its meeting in Chicago on June 10-11. The society will probably not meet again until after the war is over.

Very truly yours,

COLLIER F. MARTIN,  
*Secretary-Treasurer.*

#### LETTER TO THE EDITOR

SUGAR, ALCOHOL AND GLYCERIN IN MEDICINES.

*To the Editor:*

As you are aware, there is urgent need for the country to use with the utmost care, our stocks of sugar, alcohol and glycerin. It has come to our attention through the work of Prof. Wimmer of New York and Mr. F. A. Upsher Smith of St. Paul, Minn., that it is possible to reduce largely the amount of these materials used in medicines by the adoption of infusions, decoctions and solid forms of medication, such as capsules, in place of elixirs, syrups, fluid extracts and tinctures.

As the choice of medicine rests with the physician, we feel that the extent to which this conservation program is successful rests largely with the physician, and we urge upon physicians throughout the country the desirability of prescribing extemporaneously wherever possible.

It is really desirable that the editors of Pharmaceutical and medical journals, deans and professors of colleges, and secretaries of state, county and city associations should see that the matter is fully discussed at meetings of physicians and druggists and should do all within their power to assist this conservation movement, which cannot fail to be of material assistance to the country, since "Food Will Win the War."

May we depend upon you for your active co-operation in this matter?

Yours very truly,

UNITED STATES FOOD ADMINISTRATION.

Per Charles W. Merrill,

*Division of Chemicals, Sisal and Jute.*

## BOOK REVIEWS

**NOSTRUMS FOR KIDNEY DISEASES AND DIABETES.** Prepared and issued by the Propaganda Department of The Journal of the American Medical Association. 47 pages; deals with 34 nostrums; illustrated. American Medical Association, 535 North Dearborn St., Chicago. Paper, 10 cents post-paid.

This is the latest pamphlet issued by The Propaganda Department of *The Journal of the American Medical Association*, as part of its work in giving the medical profession and the public the facts regarding different phases of the nostrum evil and quackery. Nostrums for kidney disease and diabetes are grouped together in one pamphlet, not because there is any essential relation between diabetes and kidney disease, but because the average quack makes no distinction between the two conditions and recommends his nostrum indiscriminately for both. It is not necessary to tell physicians that drugs will not cure either kidney disease or diabetes, but it is necessary to apprise the public of this fact. Whatever justification there may be for the sale of home remedies for self-treatment, there is no excuse either moral or economic for selling preparations recommended for the self-treatment of such serious conditions as diabetes and kidney disease. Every "patent medicine" sold for the cure of these diseases is potentially dangerous and inherently vicious. The pamphlet is an interesting and instructive one to put in the hands of the layman.

**NEUROSYPHILIS.** E. E. SOUTHARD, M. D., and H. C. SOLOMON, M. D. W. M. Leonard, publisher, Boston, 1917.

This treatise upon neurosyphilis is published as monograph number two by the Psychopathic Hospital of Boston. It portrays in excellent form 137 case histories, including focal cerebral syphilis, general paresis, tabes, feeble-mindedness, the syphilitic with an intercurrent psychosis and cases which have shown merely minute changes in personality to the most profound injury to the adaptative mechanism in life. Anatomically the cases were divided into meningeal, vascular, parenchymatous, meningo-vascular, meningo-parenchymatous, meningo-vasculo-parenchyma-

tous and a toxic irritative type. Those cases coming to autopsy are all carefully and clearly analyzed from the pathological standpoint and the clinical symptom-complex correlated with the pathological findings. Through this correlation of clinical symptoms and pathological findings, it is found that many tissue changes syphilitic in origin occur which did not evince corresponding clinical signs and vice versa. Such observations as these would call for speculation regarding the biological function of tissue, the cellular physiology and the general metabolic activities occurring in syphilis.

The authors have carefully tabulated the symptoms and their frequency as they occur in those disorders affecting the cord and brain, emphasizing their value. The diagnostic importance of a complete analysis of the spinal fluid and its relation to prognosis in treatment is carefully observed throughout the entire book. The interpretation of these findings bears comment as indicating a most careful observation.

The Sections on Puzzles and Errors and the Social and Medico-legal aspects show the crying need of a more thorough observation as to the onset of signs and symptoms when these patients are in the hands of the general practitioner as well as demonstrating the vast importance of "following up" many cases for the welfare of society.

Under treatment in addition to the intramuscular and intravenous methods, the discussion of intraspinal, subdural and intraventricular methods is carefully considered. It would appear that there is no hard and fast rule in the treatment of neurosyphilis, that every patient has his own syphilis and that any improvement or even a cure depends upon the interpretation of the case in its entirety and the institution, under sound judgment of the therapist, of intensive treatment.

The chapter on neurosyphilis and the war is extremely interesting and shows the absolute necessity of the careful observation and the proper interpretation of mental symptoms in drafted men and urges adequate provision for care and treatment.

The careful work reported in summary form in this book is based upon a decided appreciative understanding of neuropathology, neuroserology and psychopathology, and should be of considerable help to the clinician as well as the therapist.

F. J. F.